114.5 CMR 11: CRITERIA AND PROCEDURES FOR THE SUBMISSION OF HEALTH PLAN DATA

Section

11.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.5 CMR 11.00 establishes the data and information that every health insurance plan in the Commonwealth must provide to the Division of Health Care Finance and Policy to be used to create the health plan report card required by M.G.L. c. 118G, § 24. 114.5 CMR 11.00 is effective April 8, 2005.

(2) Authority 114.5 CMR 11.00 is adopted pursuant to M.G.L. c. 118G, § 24.

11.02: Definitions

Agency for Healthcare Research and Quality (AHRQ): is an agency within the U.S. Department of Health and Human Services that funds and conducts research on healthcare quality which includes maintaining the National CAHPS Benchmarking Database (NCBD).

Bureau of Managed Care: is an office within the Division of Insurance, a state government agency that regulates insurers in Massachusetts. The Bureau of Managed Care is responsible for accrediting managed health insurance plans in Massachusetts pursuant to M.G.L. c.176O, sec. 2.

Consumer Assessment of Health Plans (CAHPS): is a tool developed under the direction of the Agency for Healthcare Research and Quality, a U.S. Government agency, containing surveys that ask consumers about their experiences with their healthcare.

Division: The Division of Health Care Finance and Policy (DHCFP) established pursuant to M.G.L. c. 118G.

Health Insurance Plan (HIP): For purposes of this regulation, Health Insurance Plan shall be defined as 'carrier' is defined in M.G.L. c.176O, sec. 1. An insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

Health Plan Employer Data and Information Set (HEDIS®): is a compilation of information about American health plans to compare their performance on important dimensions of care and service.

Member: person covered in plans that are issued to Massachusetts groups or individuals.

National CAHPS™ Benchmarking Database (NCBD): is a set of information, maintained by AHRQ, that compares health plans based upon consumers' experiences as measured through CAHPS survey instruments.

National Committee for Quality Assurance (NCQA): is a private, not-for-profit organization which assesses and reports on the quality of the nation's managed care plans through an accreditation and performance measurement program, including member satisfaction, quality of care, access, and customer service.

Office of Patient Protection (OPP): is an office within the Massachusetts Department of Public Health. The OPP's responsibilities include making available to the public a report card on managed care health plans in Massachusetts pursuant to M.G.L. c.111 section 217.

Preferred Provider Organization (PPO): is a HIP that provides a subset of licensed providers from which the PPO's members can choose to seek care without receiving permission from a primary care physician or other clinician.

Quality Compass: is a data product sold by the National Committee on Quality Assurance (NCQA), which contains complete validated HEDIS results for all plans who submit their HEDIS data to NCQA for publication.

Reporting Year: is the annual calendar year during which Health Insurance Plans are required to submit HEDIS or CAHPS data.

Survey Year: is the annual calendar year preceding the reporting year and consisting of four quarters during which CAHPS data on plan enrollees is surveyed and compiled by the Health Insurance Plans for reporting purposes.

11.03: Reporting Requirements

(1) Required Reports and Due Dates. Health Insurance Plans licensed in Massachusetts shall comply with the following reporting requirements:

(a). Each HIP that annually collects HEDIS data shall submit that data during the reporting year to the Division.

1. Health Insurance Plans that submit HEDIS data during the reporting year to NCQA by the deadline established by NCQA for publication in Quality Compass will have met their requirement for submission to DHCFP and OPP, as long as NCQA assures each HIP that the Quality Compass product will be available to DHCFP and OPP for use in the report card by August 15 of the reporting year. In any year for which the August 15 deadline cannot be assured for Quality Compass availability, those Health Insurance Plans submitting data to NCQA for Quality Compass publication shall submit their data directly and concurrently to

DHCFP and OPP by July 31 of that year using an electronic data file format to be determined by DHCFP or as prescribed by NCQA.
2. Health Insurance Plans that submit HEDIS data to NCQA but fail to meet NCQA's deadline shall submit their data directly and concurrently to DHCFP and OPP by July 31 of the reporting year using an electronic data file format to be determined by DHCFP or as prescribed by NCQA.
3. Health Insurance Plans that collect HEDIS data but that do not submit to NCQA, or do submit to NCQA but decline publication in Quality Compass, shall submit their data directly and concurrently to DHCFP and OPP by July 31 of the reporting year using an electronic data file format to be determined by DHCFP or using the same format as that required by NCQA.

(b). Each HIP must annually collect CAHPS survey data of their enrollees and shall submit that data by July 1st of the reporting year to the National CAHPS Benchmarking Database (NCBD) maintained by the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health and Human Services. The Division and OPP will arrange retrieval of relevant reports from NCBD. A Health Insurance Plan's timely submission of CAHPS data to NCBD during the reporting year shall be deemed or otherwise constitute satisfaction of the reporting requirement to the Division.

(c). If NCQA expands the types of plans it accredits to include, for example, Preferred Provider Organizations (PPOs) or stand-alone dental or vision plans, those plans must comply with the requirements set forth in 114.5 CMR 11.03(1)(a) and (b) as applicable. The report card will be careful to make reasonable comparisons between types of plans.

(d). Each HIP shall file or make available to the Division upon request other information that is or will be routinely collected by health plan accrediting organizations, regulatory agencies and the like, and that is reasonably similar to the types of information already being collected pursuant to 114.5 CMR 11. Each HIP shall provide the requested information within 15 business days from the date of the request, unless a different time is specified. The Division may, for cause, extend the filing date of the requested information, in response to a written request for an extension of time.

(2) Waivers. Health Insurance Plans may be entitled to a waiver from the CAHPS data reporting requirements to the Division depending upon plan membership size.

(a). Health Insurance Plans with more than 10,000 members for each of the 4 quarters within the survey year and at least 5,000 members ages 18-64 in each of the 4 quarters of the survey year are required to report their CAHPS data to the Division during the reporting year and may not apply for a waiver.

(b). Health Insurance Plans with 5,000-10,000 members for each of the 4 quarters within the survey year and 5,000 or more members ages 18-64 in each of the 4 quarters of the survey year are required to report their CAHPS data to the Division during the reporting year unless the plan obtains a waiver from the Division.

(i) Health Insurance Plans with between 5,000 to 10,000 members that are able to demonstrate financial burden resulting from the reporting requirements may apply for a waiver for the current reporting year from the Division. In applying for a waiver, Health Insurance Plans must submit (1) the per member per month cost of administering the survey; and (2) documentation demonstrating financial burden, including, but not limited to, the cost of survey administration as a percent of the plans' contributions to reserves/surplus or returns to shareholders based on financial statements from the most recently audited year. A waiver request together with supporting documentation must be submitted to the Division by April 1st of the current reporting year.

(3) Exemptions. Certain Health Insurance Plans are exempt from the HEDIS and CAHPS data reporting requirements to the Division.

(a) Health Insurance Plans with fewer than 5,000 total members ages 18-64 in any of the 4 quarters within the survey year are exempt from the CAHPS reporting requirements but may submit their data to NCBD though they are not required to do so.

(b) Health Insurance Plans that have filed the necessary paperwork with the Division of Insurance to cancel all existing memberships and as a result forfeit their license or becomes inactive within the reporting year are exempt from the reporting requirements to the Division.

(c) Stand-alone dental, vision and prescriptions drug plans are exempt from the reporting requirements to the Division until such time that NCQA accredits these plans. Following NCQA accreditation, stand-alone dental, vision, and prescription drug plans shall be required to comply with the HEDIS and CAHPS data reporting requirements to the Division.

(d) Medicare Managed Care plans are exempt from the reporting requirements to the Division since CAHPS data is available through the Centers for Medicare & Medicaid Services.

(4) Enforcement of Reporting Requirements. The Division shall notify both the Bureau of Managed Care within the Division of Insurance and OPP within the Department of Public Health of any Health Insurance Plans that fail to meet the reporting requirements of 114.5 CMR 11 and shall note the non-compliance in the current health plan report card.

11.04 Severability

The provisions of 114.5 CMR 11.00 are severable. If any provision or the application of any provision to any HIP or circumstance is held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provision of 114.5 CMR 11.00 or the application of any such provision to HIPs or circumstances other than those held invalid.

11.05 Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.5 CMR 11.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.5 CMR 11.00.

REGULATORY AUTHORITY
114.5 CMR 11.00: M.G.L. c. 118G.